

CALIFORNIA DEPARTMENT OF EDUCATION
 Child Development Division
 CD-9606 (Revised: 02/04)

NOTE: When applicable, this form is to be completed and used with form, CD-9600.

STATEMENT OF INCAPACITY (PARENT OR CARETAKER)

Please print or type information.

PART I - To be completed by authorized agency representative.			
Instructions In order for the child (or children) of a parent or caretaker to be eligible to receive child development services, the California Department of Education requires verification that the medical or psychiatric special needs of the parent or caretaker cannot be met without the provision of child development services.			
PARENT(S) OR CARETAKER(S) NAME <i>Maria Vallejo</i>		PARENT(S) OR CARETAKER(S) SIGNATURE <i>[Signature]</i>	
The parent or caretaker listed above has authorized us to contact you for such verification. Your cooperation in answering the questions and returning this form within two weeks to the agency listed below will enable our agency to establish eligibility.			
AGENCY Children of the Rainbow		AUTHORIZED AGENCY REPRESENTATIVE (Please print.) Jasmine Jackson	TELEPHONE NUMBER (619) 615-0652
ADDRESS 3078 L Street		CITY San Diego	ZIP CODE 92102

PART II - To be completed by a licensed professional.															
NATURE OF INCAPACITY <i>Mother in hospital undergoing tx</i>						PROBABLE DATES OF INCAPACITY From <i>Aug 4, 2008</i> To <i>Sept 30, 2008</i>									
Does the nature of the incapacity prevent the parent or caretaker from caring for the child without assistance for at least some part of the day? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No						NUMBER OF HOURS PER DAY CHILD CARE REQUIRED									
						<table border="1"> <tr> <th>Mon</th> <th>Tues</th> <th>Wed</th> <th>Thurs</th> <th>Fri</th> <th>Sat</th> <th>Sun</th> </tr> <tr> <td>24h</td> <td>24h</td> <td>24h</td> <td>24h</td> <td>24h</td> <td>24h</td> <td>24h</td> </tr> </table>		Mon	Tues	Wed	Thurs	Fri	Sat	Sun	24h
Mon	Tues	Wed	Thurs	Fri	Sat	Sun									
24h	24h	24h	24h	24h	24h	24h									
						Is hospitalization required at this time? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <i>N/A</i>									

COMMENTS (Attached a separate sheet, if necessary):

*Mother has been hospitalized for severe disease and continues to need hospitalization.
 Appropriate child care service*

LICENSED PROFESSIONAL SIGNATURE <i>[Signature]</i> CABINIER		DATE 9/10/08	TELEPHONE 615-267-0220	
LICENSE / CREDENTIAL TYPE MD		LICENSE / CREDENTIAL NUMBER AD45503		
ADDRESS 3400 East 8th St Suite #107		CITY National City	STATE CA	ZIP CODE 91950